

**House File 2438 - Introduced**

HOUSE FILE 2438  
BY HARRIS and YOUNG

**A BILL FOR**

1 An Act relating to health carriers and payment of claims, audits,  
2 and standards of conduct; prior authorizations and utilization  
3 review organizations; and providing civil penalties and  
4 including applicability provisions.  
5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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DIVISION I

HEALTH INSURANCE TRADE PRACTICES

Section 1. Section 507B.4, subsection 3, paragraph j, subparagraph (15), Code 2026, is amended to read as follows:

(15) Failing to comply with the procedures for auditing claims submitted by health care providers as set forth in section 507B.15 or as otherwise provided by rule of the commissioner.

However, this subparagraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 2. Section 507B.4, subsection 3, Code 2026, is amended by adding the following new paragraphs:

NEW PARAGRAPH. w. *Standards of conduct.* Any violation of section 507B.16 by a health carrier.

NEW PARAGRAPH. x. *Prior authorization — peer review.* Any violation of section 514F.8A by a utilization review organization or a health carrier.

Sec. 3. Section 507B.4A, subsection 2, paragraph a, Code 2026, is amended by striking the paragraph and inserting in lieu thereof the following:

a. An insurer shall comply with all of the following:

(1) An insurer shall either accept and pay or deny a clean claim no later than thirty calendar days after the date the insurer receives an electronic claim submission, or no later than forty-five calendar days after the date the insurer receives a claim submitted on paper.

(2) After the date of payment of a clean claim, an insurer shall not retroactively deny, reduce, or recoup payment of the claim unless the insurer first provides written notice and evidence of any of the following to the health care provider that submitted the claim:

(a) The claim submission included a misrepresentation.

(b) The claim submission was fraudulent.

(c) The claim submission was a duplicate submission of a

1 claim for which the insurer previously paid.

2 Sec. 4. Section 507B.4A, subsection 2, Code 2026, is amended  
3 by adding the following new paragraph:

4 NEW PARAGRAPH. 0c. For purposes of this subsection,  
5 "insurer" includes all of the following:

6 (1) An insurer providing accident and sickness insurance  
7 under chapter 509, 514, or 514A; a health maintenance  
8 organization; or another entity providing health insurance or  
9 health benefits subject to state insurance regulation.

10 (2) The medical assistance program under chapter 249A and the  
11 healthy and well kids in Iowa (Hawki) program under chapter 514I.

12 (3) A managed care organization acting pursuant to a contract  
13 with the department of health and human services to administer  
14 the medical assistance program under chapter 249A, or the healthy  
15 and well kids in Iowa (Hawki) program under chapter 514I.

16 Sec. 5. NEW SECTION. **507B.15 Health carriers — audits and**  
17 **claim submissions.**

18 1. As used in this section, unless the context otherwise  
19 requires:

20 a. "Audit" means a review, investigation, or request for  
21 additional documentation by a health carrier before or after  
22 issuing payment on a clean claim to a health care provider.

23 b. "Clean claim" means a properly completed paper or  
24 electronic billing instrument containing all reasonably necessary  
25 information that does not involve coordination of benefits  
26 for third-party liability, preexisting condition investigations,  
27 or subrogation, and that does not involve the existence  
28 of particular circumstances requiring special treatment that  
29 prevents a prompt payment from being made.

30 c. "Health care provider" means the same as defined in  
31 section 514J.102.

32 d. "Health carrier" means an entity subject to the insurance  
33 laws and regulations of this state, or subject to the  
34 jurisdiction of the commissioner, including an insurance company  
35 offering sickness and accident plans, a health maintenance

1 organization, a nonprofit health service corporation, a plan  
2 established pursuant to chapter 509A for public employees, or any  
3 other entity providing a plan of health insurance, health care  
4 benefits, or health care services. "Health carrier" includes the  
5 following:

6 (1) The medical assistance program under chapter 249A and the  
7 healthy and well kids in Iowa (Hawki) program under chapter 514I.

8 (2) A managed care organization acting pursuant to a contract  
9 with the department of health and human services to administer  
10 the medical assistance program under chapter 249A, or the healthy  
11 and well kids in Iowa (Hawki) program under chapter 514I.

12 2. If a health carrier conducts an audit of a clean  
13 claim submitted by a health care provider, the health carrier  
14 shall reimburse the health care provider for the reasonable  
15 administrative costs incurred and documented by the health care  
16 provider to respond to the audit, including but not limited to  
17 staff time, copying, and record retrieval.

18 3. a. A health carrier that conducts an audit shall notify  
19 the health care provider that submitted the clean claim of the  
20 initiation of the audit no later than fifteen calendar days after  
21 the date the health carrier selects the clean claim for audit.

22 b. A health carrier shall complete an audit of a clean claim  
23 and issue a determination on the clean claim to the health care  
24 provider that submitted the clean claim no later than forty-five  
25 calendar days after the date that the health carrier receives all  
26 requested documentation regarding the clean claim from the health  
27 care provider.

28 c. A health care provider that submitted a clean claim that  
29 is the subject of an audit by a health carrier, and that receives  
30 an adverse determination regarding the clean claim, may appeal  
31 the adverse determination no later than thirty calendar days  
32 after the date the health care provider receives the audit  
33 determination.

34 d. A health carrier shall consider an appeal under  
35 subparagraph "c", and issue a final determination on the clean

1 claim that is the subject of the appeal, no later than fourteen  
2 calendar days after the date the health carrier receives notice  
3 of the appeal.

4 e. If a health carrier violates this subsection, the clean  
5 claim shall be automatically approved by the health carrier and  
6 promptly paid, including interest at the rate of ten percent per  
7 annum.

8 4. a. A violation of this section by a health carrier shall  
9 constitute an unfair method of competition or unfair or deceptive  
10 act or practice under section 507B.4.

11 b. A health carrier that violates this section shall be  
12 subject to civil penalties under section 505.7A.

13 c. In any action brought by a health care provider for a  
14 violation of this section, the health care provider shall be  
15 entitled to recover costs of litigation, including reasonable  
16 attorney fees and other litigation expenses incurred by the  
17 health care provider, regardless of whether the health care  
18 provider prevails in such action.

19 5. The commissioner shall adopt rules pursuant to chapter 17A  
20 to administer and enforce this section.

21 6. a. This section shall not apply to a claim that is under  
22 active fraud investigation by a state or federal authority.

23 b. This section shall not apply to a federal program where  
24 audits are mandated by federal law.

25 Sec. 6. NEW SECTION. **507B.16 Health carriers — standards**  
26 **of conduct.**

27 1. As used in this section:

28 a. "Health care provider" means the same as defined in  
29 section 514J.102.

30 b. "Health carrier" means an entity subject to the insurance  
31 laws and regulations of this state, or subject to the  
32 jurisdiction of the commissioner, including an insurance company  
33 offering sickness and accident plans, a health maintenance  
34 organization, a nonprofit health service corporation, a plan  
35 established pursuant to chapter 509A for public employees, or any

1 other entity providing a plan of health insurance, health care  
2 benefits, or health care services. "Health carrier" includes the  
3 following:

4 (1) The medical assistance program under chapter 249A and the  
5 healthy and well kids in Iowa (Hawki) program under chapter 514I.

6 (2) A managed care organization acting pursuant to a contract  
7 with the department of health and human services to administer  
8 the medical assistance program under chapter 249A, or the healthy  
9 and well kids in Iowa (Hawki) program under chapter 514I.

10 2. A health carrier shall not impose on a health care  
11 provider, directly or indirectly, any financial penalty,  
12 reimbursement reduction, or administrative fee, or terminate a  
13 health care provider's participation in the health carrier's  
14 network, based on the health care provider's referral to, or  
15 affiliation with, an out-of-network health care provider.

16 3. A health carrier shall not interfere with, or participate  
17 in any capacity in, a health care provider's decisions regarding  
18 staffing and referral, except as otherwise provided by law.

19 4. A health carrier shall not offer, attempt to enforce,  
20 or enforce an agreement, or an amendment to an agreement, with  
21 a health care provider without providing an opportunity for  
22 negotiation. A contract term that imposes an unreasonable or  
23 unconscionable obligation on a health care provider shall be void  
24 and unenforceable.

25 5. a. A violation of this section by a health carrier shall  
26 constitute an unfair method of competition or unfair or deceptive  
27 act or practice under section 507B.4.

28 b. A health carrier that violates this section shall be  
29 subject to civil penalties according to section 505.7A.

30 c. In any action brought by a health care provider against  
31 a health carrier for a violation of this section, the health  
32 care provider shall be entitled to recover costs of litigation,  
33 including reasonable attorney fees and other expenses incurred  
34 by the health care provider in the course of the litigation,  
35 regardless of whether the health care provider prevails in such

1 action.

2 6. The commissioner shall adopt rules pursuant to chapter 17A  
3 to administer and enforce this section.

4 DIVISION II

5 PRIOR AUTHORIZATIONS

6 Sec. 7. NEW SECTION. **514F.8A Prior authorizations — peer**  
7 **review.**

8 1. For purposes of this section:

9 a. "*Clinical peer*" means a health care professional that  
10 meets all of the following requirements:

11 (1) The health care professional practices in the same or  
12 similar specialty as the health care provider that requested a  
13 prior authorization.

14 (2) The health care professional has experience managing  
15 the specific medical condition or administering the health care  
16 service that is the subject of the prior authorization request.

17 (3) The health care professional is employed by or contracted  
18 with the utilization review organization or health carrier to  
19 which a health care provider submitted a request for prior  
20 authorization.

21 b. "*Covered person*" means the same as defined in section  
22 514F.8.

23 c. "*Downgrade*" means a decision by a health carrier or  
24 utilization review organization to change an expedited or urgent  
25 request for prior authorization to a standard determination, or  
26 otherwise modify a health care service that is the subject of  
27 a request for prior authorization to a lower-level health care  
28 service.

29 d. "*Health care professional*" means the same as defined in  
30 section 514J.102.

31 e. "*Health care provider*" means the same as defined in  
32 section 514F.8.

33 f. "*Health care services*" means the same as defined in  
34 section 514F.8.

35 g. "*Health carrier*" means an entity subject to the insurance

1 laws and regulations of this state, or subject to the  
2 jurisdiction of the commissioner, including an insurance company  
3 offering sickness and accident plans, a health maintenance  
4 organization, a nonprofit health service corporation, a plan  
5 established pursuant to chapter 509A for public employees, or any  
6 other entity providing a plan of health insurance, health care  
7 benefits, or health care services. "Health carrier" includes the  
8 following:

9 (1) The medical assistance program under chapter 249A and the  
10 healthy and well kids in Iowa (Hawki) program under chapter 514I.

11 (2) A managed care organization acting pursuant to a contract  
12 with the department of health and human services to administer  
13 the medical assistance program under chapter 249A, or the healthy  
14 and well kids in Iowa (Hawki) program under chapter 514I.

15 h. "Physician" means a doctor of medicine and surgery, or  
16 a doctor of osteopathic medicine and surgery, licensed in this  
17 state.

18 i. "Prior authorization" means the same as defined in section  
19 514F.8.

20 j. "Qualified reviewer" means a physician that meets all of  
21 the following requirements:

22 (1) The physician practices in the same or a similar  
23 specialty as the health care provider that requested a prior  
24 authorization.

25 (2) The physician has the training and expertise to treat the  
26 specific medical condition that is the subject of a request for  
27 prior authorization, including sufficient knowledge to determine  
28 whether the health care service that is the subject of the  
29 request is medically necessary or clinically appropriate.

30 (3) The physician is employed by or contracted with the  
31 utilization review organization or health carrier to which a  
32 health care provider submitted a request for prior authorization.

33 k. "Utilization review organization" means the same as  
34 defined in section 514F.8.

35 2. A utilization review organization shall not deny or

1 downgrade a request for prior authorization unless all of the  
2 following requirements are met:

3     a. The decision to deny or downgrade the request is made by  
4 either of the following:

5         (1) A qualified reviewer, if the health care provider  
6 requesting prior authorization is a physician.

7         (2) A clinical peer, if the health care provider requesting  
8 prior authorization is not a physician.

9     b. The utilization review organization provides the health  
10 care provider that requested the prior authorization all of the  
11 following:

12         (1) A written statement that cites the specific reasons  
13 for the denial or downgrade, including any coverage criteria  
14 or limits, or clinical criteria, that the utilization review  
15 organization considered or that was the basis for the denial or  
16 downgrade. The written statement shall be signed by either of  
17 the following:

18             (a) The qualified reviewer that made the denial or downgrade  
19 determination, if the health care provider that requested prior  
20 authorization is a physician.

21             (b) The clinical peer that made the denial or downgrade  
22 determination, if the health care provider that requested prior  
23 authorization is not a physician.

24         (2) A written explanation of the utilization review  
25 organization's appeals process. The utilization review  
26 organization shall also provide the written explanation to the  
27 covered person for whom prior authorization was requested.

28         (3) A written attestation that is either of the following:

29             (a) If the health care provider that requested prior  
30 authorization is a physician, a written attestation that the  
31 qualified reviewer who made the denial or downgrade determination  
32 practices in the same or a similar specialty as the health  
33 care provider, and has the requisite training and expertise to  
34 treat the medical condition that is the subject of the request  
35 for prior authorization, including sufficient knowledge to

1 determine whether the health care service is medically necessary  
2 or clinically appropriate. The attestation shall include  
3 the qualified reviewer's name, national provider identifier,  
4 state medical license number, board certifications, specialty  
5 expertise, and educational background.

6 (b) If the health care provider that requested prior  
7 authorization is not a physician, a written attestation that  
8 the clinical peer who made the denial or downgrade determination  
9 practices in the same or a similar specialty as the health  
10 care provider, and the clinical peer has experience managing  
11 the specific medical condition or administering the health  
12 care service that is the subject of the request for prior  
13 authorization. The attestation shall include the clinical peer's  
14 name, national provider identifier, state medical license number,  
15 board certifications, specialty expertise, and educational  
16 background.

17 3. At the request of the requesting health care provider,  
18 a utilization review organization that denies a request for  
19 prior authorization shall, no later than seven business days  
20 after the date that the utilization review organization notifies  
21 the requesting health care provider of the denial, conduct a  
22 consultation either in person or remotely, as follows:

23 a. Between the health care provider and a qualified reviewer,  
24 if the health care provider requesting prior authorization is a  
25 physician.

26 b. Between the health care provider and a clinical peer, if  
27 the health care provider requesting prior authorization is not a  
28 physician.

29 4. a. If a utilization review organization's decision to  
30 deny or downgrade a request for prior authorization is appealed  
31 by the requesting health care provider or covered person, the  
32 appeal shall be conducted by either of the following:

33 (1) A qualified reviewer, if the health care provider  
34 requesting prior authorization is a physician.

35 (2) A clinical peer, if the health care provider requesting

1 prior authorization is not a physician.

2     b. A qualified reviewer or clinical peer involved in the  
3 initial denial or downgrade determination of a request for prior  
4 authorization that is the subject of an appeal shall not conduct  
5 the appeal.

6     c. When conducting an appeal of a request for prior  
7 authorization, the qualified reviewer or clinical peer shall  
8 consider the known clinical aspects of the health care services  
9 under review, including but not limited to medical records  
10 relevant to the covered person's medical condition that is the  
11 subject of the health care services for which prior authorization  
12 is requested, and any relevant medical literature submitted by  
13 the health care provider as part of the appeal.

14     5. a. A violation of this section by a utilization review  
15 organization or a health carrier shall constitute an unfair  
16 method of competition or unfair or deceptive act or practice  
17 under section 507B.4.

18     b. A utilization review organization or a health carrier  
19 that violates this section shall be subject to civil penalties  
20 according to section 505.7A.

21     c. In any action brought by a health care provider against  
22 a utilization review organization or a health carrier for a  
23 violation of this section, the health care provider shall be  
24 entitled to recover costs of litigation, including reasonable  
25 attorney fees and other expenses incurred by the health care  
26 provider in the course of the litigation, regardless of whether  
27 the health care provider prevails in such action.

28     6. The commissioner of insurance may adopt rules pursuant to  
29 chapter 17A to administer this section.

30     Sec. 8. NEW SECTION. **514F.8B Prior authorizations —**  
31 **exemptions.**

32     1. For purposes of this section:

33     a. "Covered person" means the same as defined in section  
34 514F.8.

35     b. "Health benefit plan" means the same as defined in section

1 514J.102.

2 c. "Health care professional" means the same as defined in  
3 section 514J.102.

4 d. "Health carrier" means an entity subject to the insurance  
5 laws and regulations of this state, or subject to the  
6 jurisdiction of the commissioner, including an insurance company  
7 offering sickness and accident plans, a health maintenance  
8 organization, a nonprofit health service corporation, a plan  
9 established pursuant to chapter 509A for public employees, or any  
10 other entity providing a plan of health insurance, health care  
11 benefits, or health care services. "Health carrier" includes the  
12 following:

13 (1) The medical assistance program under chapter 249A and the  
14 healthy and well kids in Iowa (Hawki) program under chapter 514I.

15 (2) A managed care organization acting pursuant to a contract  
16 with the department of health and human services to administer  
17 the medical assistance program under chapter 249A, or the healthy  
18 and well kids in Iowa (Hawki) program under chapter 514I.

19 e. "Prior authorization" means the same as defined in section  
20 514F.8.

21 f. "Utilization review" means the same as defined in section  
22 514F.4, subsection 3.

23 2. A health carrier shall not require prior authorization  
24 for, or impose additional utilization review requirements on, a  
25 covered person for any of the following:

26 a. A cancer-related screening or cancer-related preventative  
27 health care service if the cancer-related screening or  
28 cancer-related service is recommended by the covered person's  
29 health care professional based on the most recently updated  
30 national comprehensive cancer network clinical practice  
31 guidelines in oncology.

32 b. Diagnosis and treatment of a health condition that  
33 develops or becomes evident in a covered person while the  
34 covered person is receiving treatment at an inpatient facility,  
35 and the health condition is reasonably determined by a health

1 care professional to be a life threatening condition unless the  
2 covered person receives immediate assessment and treatment.

3 3. The commissioner of insurance may adopt rules pursuant to  
4 chapter 17A to administer this section.

5 Sec. 9. APPLICABILITY. This division of this Act applies to  
6 all of the following:

7 1. Health benefit plans delivered, issued for delivery,  
8 continued, or renewed in this state on or after January 1, 2027.

9 2. Requests for prior authorization for a health care  
10 service, if the request is made before January 1, 2027, and the  
11 request has not been finally determined on or before that date.

12 EXPLANATION

13 The inclusion of this explanation does not constitute agreement with  
14 the explanation's substance by the members of the general assembly.

15 This bill relates to health carriers and payment of claims,  
16 audits, and standards of conduct, prior authorizations, and  
17 utilization review organizations.

18 DIVISION I — HEALTH INSURANCE TRADE PRACTICES. Under  
19 current law, an insurer shall either accept and pay or deny a  
20 clean claim. Under the bill, an insurer shall either accept and  
21 pay or deny a clean claim no later than 30 days after receiving  
22 an electronic claim submission, or 45 days after receiving  
23 a claim submitted on paper. After paying a clean claim,  
24 the insurer shall not retroactively deny, reduce, or recoup  
25 payment of the claim, except if the claim submission included a  
26 misrepresentation, was fraudulent, or was a duplicate submission,  
27 and the insurer first provides written notice including evidence  
28 to the health care provider (provider) that submitted the claim  
29 of the misrepresentation, fraud, or duplicate submission.

30 If a health carrier (carrier) conducts an audit of a  
31 clean claim, the carrier shall reimburse the provider for the  
32 reasonable administrative costs incurred by the provider to  
33 respond to the audit. "Audit" and "clean claim" are defined in  
34 the bill.

35 A carrier that conducts an audit shall notify the provider

1 of the initiation of the audit no later than 15 days after  
2 selecting the clean claim for audit. A carrier shall complete  
3 an audit and issue a determination on the clean claim within 45  
4 days of receiving all requested documentation from the provider.  
5 A provider that submitted a clean claim subject to an audit,  
6 and that receives an adverse determination, may appeal the  
7 determination within 30 days. A carrier shall consider an appeal  
8 and issue a final determination on the clean claim no later than  
9 14 days after receiving notice of the appeal. If a carrier  
10 violates the audit timeline requirements, the clean claim shall  
11 be automatically approved and promptly paid, including interest  
12 at the rate of 10 percent per annum.

13 The audit requirements shall not apply to a claim that is  
14 under active fraud investigation by a state or federal authority,  
15 or to a federal program where audits are mandated by federal law.

16 Under the bill, a carrier shall not: (1) impose on a provider  
17 any financial penalty, reimbursement reduction, or administrative  
18 fee, or terminate a provider's participation in the carrier's  
19 network, based on the provider's referral to or affiliation with  
20 an out-of-network provider; (2) interfere with, or participate in  
21 any capacity in, a provider's decisions regarding staffing and  
22 referral, except as otherwise provided by law; and (3) offer,  
23 attempt to enforce, or enforce an agreement or amendment to an  
24 agreement with a provider without providing an opportunity for  
25 negotiation, and a contract term that violates the bill shall be  
26 void and unenforceable.

27 A violation of this division of the bill by a carrier  
28 shall constitute an unfair method of competition or unfair or  
29 deceptive act or practice. The carrier shall be subject to  
30 civil penalties. In any action brought by a provider against  
31 a carrier, the provider shall be entitled to recover costs  
32 of litigation, including reasonable attorney fees and other  
33 expenses, regardless of whether the provider prevails in such  
34 action.

35 The commissioner shall adopt rules to administer and enforce

1 this division.

2 The bill makes conforming changes to Code sections  
3 507B.4(3)(j)(15) and 507B.4(3).

4 DIVISION II — PRIOR AUTHORIZATIONS. A utilization review  
5 organization (URO) shall not deny or downgrade a request for  
6 authorization unless: (1) the decision is made by a qualified  
7 reviewer or clinical peer; and (2) the URO provides the provider  
8 requesting authorization a written statement citing the reasons  
9 for the decision, explaining the appeals process, and a written  
10 attestation as described by the bill. If a request for  
11 authorization is denied, the URO shall notify the provider within  
12 seven days and conduct a consultation as described by the bill.  
13 "Clinical peer" and "qualified reviewer" are defined in the bill.

14 If a URO's decision to deny or downgrade a request for  
15 authorization is appealed by the requesting provider or covered  
16 person, the appeal shall be conducted by a qualified reviewer  
17 or clinical peer who was not involved in the initial denial  
18 or downgrade. When conducting an appeal of a request for  
19 authorization, the qualified reviewer or clinical peer shall  
20 consider the known clinical aspects of the health care services  
21 (services) under review, including but not limited to medical  
22 records relevant to the medical condition and any relevant  
23 medical literature submitted by the provider.

24 A violation of the bill's requirements for denial or downgrade  
25 of an authorization by a URO or a carrier shall constitute  
26 an unfair method of competition or unfair or deceptive act or  
27 practice. The carrier shall be subject to civil penalties.  
28 In any action brought by a provider against a carrier, the  
29 provider shall be entitled to recover costs of litigation,  
30 including reasonable attorney fees and other expenses, regardless  
31 of whether the provider prevails in such action.

32 The commissioner may adopt rules to administer this division  
33 of the bill.

34 A carrier shall not require authorization for, or impose  
35 additional utilization review requirements on, a covered

1 person for: (1) a cancer-related screening or cancer-related  
2 preventative service recommended by the covered person's  
3 professional based on the national comprehensive cancer network  
4 clinical practice guidelines in oncology; or (2) the diagnosis  
5 and treatment of a health condition that develops or becomes  
6 evident in a covered person while receiving treatment at an  
7 inpatient facility, and the health condition is reasonably  
8 determined by a professional to be a life threatening condition  
9 unless the covered person receives immediate assessment and  
10 treatment.

11 This division of the bill applies to health benefit plans  
12 delivered, issued for delivery, continued, or renewed on or after  
13 January 1, 2027, and requests for prior authorization for a  
14 cancer-related screening or cancer-related preventative health  
15 care service if the screening or service is recommended by the  
16 covered person's professional, the request is made before January  
17 1, 2027, and the request has not been finally determined on or  
18 before that date.